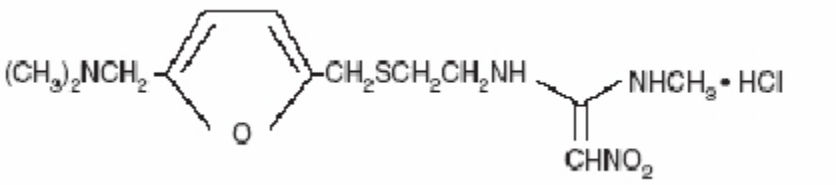
RANITIDINE - ranitidine hydrochloride injection

This Pharmacy Bulk Package is intended for preparing IV admixtures only.
Not for Direct Infusion.

Rx ONLY

DESCRIPTION

The active ingredient in Ranitidine Injection USP, is ranitidine hydrochloride (HCl), a histamine H_2-receptor antagonist. Chemically it is *N*-[2-[[[5-[(Dimethylamino)methyl]-2-furanyl]methyl]thio]ethyl]-N'-methyl-2-nitro-1,1-ethenediamine, hydrochloride. It has the following structural formula:



The molecular formula is $C_{13}H_{22}N_4O_3S$ • HCl, representing a molecular weight of 350.87.
Ranitidine hydrochloride is a white to pale yellow, granular substance that is soluble in water.
Ranitidine Injection USP is a clear, colorless to yellow, sterile, nonpyrogenic liquid. The yellow color of the liquid tends to intensify without adversely affecting potency. The pH of the injection solution is 6.7 to 7.3.
Each 1 mL of aqueous solution contains ranitidine 25 mg (as the hydrochloride); phenol 5 mg as a preservative; 0.96 mg of monobasic potassium phosphate and 2.4 mg of dibasic sodium phosphate as buffers.
A pharmacy bulk package is a container of a sterile preparation for parenteral use that contains many single doses. The contents are intended for use in a pharmacy admixture program and are restricted to the preparation of admixtures for intravenous (IV) infusion (see **DOSAGE AND ADMINISTRATION** and **DIRECTIONS FOR PROPER USE OF PHARMACY BULK PACKAGE**).

CLINICAL PHARMACOLOGY

Ranitidine is a competitive, reversible inhibitor of the action of histamine at the histamine H_2- receptors, including receptors on the gastric cells. Ranitidine does not lower serum Ca++ in hypercalcemic states. Ranitidine is not an anticholinergic agent.

Pharmacokinetics

Absorption
Ranitidine is absorbed very rapidly after intramuscular (IM) injection. Mean peak levels of 576 ng/mL occur within 15 minutes or less following a 50-mg IM dose. Absorption from IM sites is virtually complete, with a bioavailiability of 90% to 100% compared with intravenous (IV) administration.

Distribution
The volume of distribution is about 1.4 L/kg. Serum protein binding averages 15%.

Metabolism
In humans, the N-oxide is the principal metabolite in the urine; however, this amounts to <4% of the dose. Other metabolites are the S-oxide (1%) and the desmethyl ranitidine (1%). The remainder of the administered dose is found in the stool. Studies in patients with hepatic dysfunction (compensated cirrhosis) indicate that there are minor, but clinically insignificant, alterations in ranitidine half-life, distribution, clearance, and bioavailability.

Excretion
Following IV injection, approximately 70% of the dose is recovered in the urine as unchanged drug. Renal clearance averages 530 mL/min, with a total clearance of 760 mL/min. The elimination half-life is 2 to 2.5 hours.

Four patients with clinically significant renal function impairment (creatinine clearance 25 to 35 mL/min) administered 50 mg of ranitidine intravenously had an average plasma half-life of 4.8 hours, a ranitidine clearance of 29 mL/min, and a volume of distribution of 1.76 L/kg. In general, these parameters appear to be altered in proportion to creatinine clearance (see **DOSAGE AND ADMINISTRATION**).

Geriatrics
The plasma half-life is prolonged and total clearance is reduced in the elderly population due to a decrease in renal function. The elimination half-life is 3.1 hours (see **PRECAUTIONS: Geriatric Use** and **DOSAGE AND ADMINISTRATION: Dosage Adjustment for Patients with Impaired Renal Function**).

Pediatrics
There are no significant differences in the pharmacokinetic parameter values for ranitidine in pediatric patients (from 1 month up to 16 years of age) and healthy adults when correction is made for body weight. The pharmacokinetics of ranitidine in pediatric patients are summarized in Table 1.

Table 1. Ranitidine Pharmacokinetics in Pediatric Patients Following IV Dosing

Population (age)	n	Dose (mg/kg)	$T_{1/2}$ (hours)	Vd (L/kg)	CLp (mL/min/kg)
Peptic ulcer disease	6	1.25 or 2.5	2.2	1.29	11.41
	11	1.25 or 2.5	2.1	1.14	8.96
(<6 years)	6	1.25 or 2.5	1.7	0.98	9.89
(6 – 11.9 years)	6	2.5	1.9	1.04	8.77
(>12 years)					
Adults					
Peptic ulcer disease	12	0.13 -0.80	1.8	2.3	795 mL/min/1.73/m^2
(3.5 -16 years)					
Children in intensive care	17	1.0	2.4	2	11.7
(1 day – 12.6 years)					
Neonates receiving	12	2	6.6	1.8	4.3
ECMO					

$T_{1/2}$ = Terminal half-life; CLp = Plasma clearance of ranitidine.
ECMO = extracorporeal membrane oxygenation.

Plasma clearance in neonatal patients (less than 1 month of age) receiving ECMO was considerably lower (3 to 4 mL/min/kg) than observed in children or adults. The elimination half-life in neonates averaged 6.6 hours as compared to approximately 2 hours in adults and pediatric patients.

Pharmacodynamics
Serum concentrations necessary to inhibit 50% of stimulated gastric acid secretion are estimated to be 36 to 94 ng/mL. Following single IV or IM 50-mg doses, serum concentrations of ranitidine are in this range for 6 to 8 hours.

Antisecretory Activity
1. Effects on Acid Secretion: Ranitidine injection inhibits basal gastric acid secretion as well as gastric acid secretion stimulated by betazole and pentagastrin, as shown in Table 2.
Table 2. Effect of Intravenous Ranitidine on Gastric Acid Secretion

	Time After Dose, h	% Inhibition of Gastric Acid Output by Intravenous Dose, mg		
		20 mg	60 mg	100 mg
Betazole	Up to 2	93	99	99
Pentagastrin	Up to 3	47	66	77

In a group of 10 known hypersecretors, ranitidine plasma levels of 71, 180, and 376 ng/mL inhibited basal acid secretion by 76%, 90%, and 99.5%, respectively.
It appears that basal- and betazole-stimulated secretions are most sensitive to inhibition by ranitidine, while pentagastrin-stimulated secretion is more difficult to suppress.
2. Effects on Other Gastrointestinal Secretions:
Pepsin: Ranitidine does not affect pepsin secretion. Total pepsin output is reduced in proportion to the decrease in volume of gastric juice.

Intrinsic Factor: Ranitidine has no significant effect on pentagastrin-stimulated intrinsic factor secretion.

Serum Gastrin: Ranitidine has little or no effect on fasting or postprandial serum gastrin.

Other Pharmacologic Actions

1. Gastric bacterial flora — increase in nitrate-reducing organisms, significance not known.
2. Prolactin levels — no effect in recommended oral or intravenous (IV) dosage, but small, transient, dose-related increases in serum prolactin have been reported after IV bolus injections of 100 mg or more.
3. Other pituitary hormones — no effect on serum gonadotropins, TSH, or GH. Possible impairment of vasopressin release.
4. No change in cortisol, aldosterone, androgen, or estrogen levels.
5. No antiandrogenic action.
6. No effect on count, motility, or morphology of sperm.

Pediatrics

The ranitidine concentration necessary to suppress basal acid secretion by at least 90% has been reported to be 40 to 60 ng/mL in pediatric patients with duodenal or gastric ulcers.

In a study of 20 critically ill pediatric patients receiving ranitidine IV at 1 mg/kg every 6 hours, 10 patients with a baseline pH≥4 maintained this baseline throughout the study. Eight of the remaining 10 patients with a baseline of pH≤2 achieved pH≥4 throughout varying periods after dosing. It should be noted, however, that because these pharmacodynamic parameters were assessed in critically ill pediatric patients, the data should be interpreted with caution when dosing recommendations are made for a less seriously ill pediatric population.

In another small study of neonatal patients (n=5) receiving ECMO, gastric pH<4 pretreatment increased to >4 after a 2 mg/kg dose and remained above 4 for at least 15 hours.

Clinical Trials

Active Duodenal Ulcer

In a multicenter, double-blind, controlled, US study of endoscopically diagnosed duodenal ulcers, earlier healing was seen in the patients treated with oral ranitidine as shown in Table 3.

Table 3. Duodenal Ulcer Patient Healing Rates

	Oral Ranitidine*		Oral Placebo*	
	Number Entered	Healed/Evaluable	Number Entered	Healed/Evaluable
Outpatients	195		188	
Week 2		69/182 (38%)†		31/164 (19%)
Week 4		137/187 (73%)†		76/168 (45%)

*All patients were permitted p.r.n. antacids for relief of pain.

†$P<0.0001$.

In these studies, patients treated with oral ranitidine reported a reduction in both daytime and nocturnal pain, and they also consumed less antacid than the placebo-treated patients.

Table 4. Mean Daily Doses of Antacid

	Ulcer Healed	Ulcer Not Healed
Oral Ranitidine	0.06	0.71
Oral placebo	0.71	1.43

Pathological Hypersecretory Conditions (such as Zollinger-Ellison syndrome)

Ranitidine inhibits gastric acid secretion and reduces occurrence of diarrhea, anorexia, and pain in patients with pathological hypersecretion associated with Zollinger-Ellison syndrome, systemic mastocytosis, and other pathological hypersecretory conditions

(e.g., postoperative, “short-gut” syndrome, idiopathic). Use of oral ranitidine was followed by healing of ulcers in 8 of 19 (42%) patients who were intractable to previous therapy.

In a retrospective review of 52 Zollinger-Ellison patients given ranitidine as a continuous IV infusion for up to 15 days, no patients developed complications of acid-peptic disease such as bleeding or perforation. Acid output was controlled to ≤10 mEq/h.

INDICATIONS AND USAGE
Ranitidine injection is indicated in some hospitalized patients with pathological hypersecretory conditions or intractable duodenal ulcers, or as an alternative to the oral dosage form for short-term use in patients who are unable to take oral medication.

CONTRAINDICATIONS
Ranitidine injection is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS

General
1. Symptomatic response to therapy with ranitidine does not preclude the presence of gastric malignancy.

2. Since ranitidine is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSAGE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ranitidine is metabolized in the liver.

3. In controlled studies in normal volunteers, elevations in SGPT have been observed when H_2-antagonists have been administered intravenously at greater than recommended dosages for 5 days or longer. Therefore, it seems prudent in patients receiving IV ranitidine at dosages ≥100 mg q.i.d. for periods of 5 days or longer to monitor SGPT daily (from day 5) for the remainder of IV therapy.

4. Bradycardia in association with rapid administration of ranitidine injection has been reported rarely, usually in patients with factors predisposing to cardiac rhythm disturbances. Recommended rates of administration should not be exceeded (see **DOSAGE AND ADMINISTRATION**).

5. Rare reports suggest that ranitidine may precipitate acute porphyric attacks in patients with acute porphyria. Ranitidine should therefore be avoided in patients with a history of acute porphyria.

Laboratory Tests

False-positive tests for urine protein with Multistix® may occur during therapy with ranitidine, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions
Although ranitidine has been reported to bind weakly to cytochrome P-450 *in vitro*, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions that suggest that ranitidine may affect the bioavailability of certain drugs by some mechanism as yet unidentified (e.g., a pH-dependent effect on absorption or a change in volume of distribution).
Increased or decreased prothrombin times have been reported during concurrent use of ranitidine and warfarin. However, in human pharmacokinetic studies with dosages of ranitidine up to 400 mg/day, no interaction occurred; ranitidine had no effect on warfarin clearance or prothrombin time. The possibility of an interaction with warfarin at dosages of ranitidine higher than 400 mg/day has not been investigated.
In a ranitidine-triazolam drug-drug interaction study, triazolam plasma concentrations were higher during b.i.d. dosing of ranitidine than triazolam given alone. The mean area under the triazolam concentration-time curve (AUC) values in 18- to 60-year-old subjects were 10% and 28% higher following administration of 75-mg and 150-mg ranitidine tablets, respectively, than triazolam given alone. In subjects older than 60 years of age, the mean AUC values were approximately 30% higher following administration of 75-mg and 150-mg ranitidine tablets. It appears that there were no changes in pharmacokinetics of triazolam and α-hydroxytriazolam, a major metabolite, and in their elimination. Reduced gastric acidity due to ranitidine may have resulted in an increase in the availability of triazolam. The clinical significance of this triazolam and ranitidine pharmacokinetic interaction is unknown.

Carcinogenesis, Mutagenesis, Impairment of Fertility
There was no indication of tumorigenic or carcinogenic effects in life-span studies in mice and rats at oral dosages up to 2,000 mg/kg per day.
Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, Escherichia coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next 9 weeks.

Pregnancy

Teratogenic Effects: Pregnancy Category B
Reproduction studies have been performed in rats and rabbits at oral doses up to 160 times the human oral dose and have revealed no evidence of impaired fertility or harm to the fetus due to ranitidine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers
Ranitidine is secreted in human milk. Caution should be exercised when ranitidine is administered to a nursing mother.

Pediatric Use
The safety and effectiveness of ranitidine injection have been established in the age-group of 1 month to 16 years for the treatment of duodenal ulcer. Use of ranitidine in this age-group is supported by adequate and well-controlled studies in adults, as well as additional pharmacokinetic data in pediatric patients, and an analysis of the published literature.
Safety and effectiveness in pediatric patients for the treatment of pathological hypersecretory conditions have not been established.
Limited data in neonatal patients (less than one month of age) receiving ECMO suggest that ranitidine may be useful and safe for increasing gastric pH for patients at risk of gastrointestinal hemorrhage.

Geriatric Use
Clinical studies of ranitidine injection did not include sufficient numbers of subjects aged 65 and over to determine whether they responded differently from younger subjects. However, in clinical studies of oral formulations of ranitidine, of the total number of subjects enrolled in US and foreign controlled clinical trials, for which there were subgroup analyses, 4,197 were 65 and over, while 899 were 75 and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.
This drug is known to be substantially excreted by the kidney and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, caution should be exercised in dose selection, and it may be useful to monitor renal function (see **CLINICAL PHARMACOLOGY: Pharmacokinetics: Geriatrics** and **DOSAGE AND ADMINISTRATION:Dosage Adjustment for Patients with Impaired Renal Function**).

ADVERSE REACTIONS
Transient pain at the site of IM injection has been reported. Transient local burning or itching has been reported with IV administration of ranitidine.
The following have been reported as events in clinical trials or in the routine management of patients treated with oral or parenteral ranitidine. The relationship to therapy with rantitidine has been unclear in many cases. Headache, sometimes severe, seems to be related to administration of ranitidine.

Central Nervous System
Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported. Rare reports of reversible involuntary motor disturbances have been received.

Cardiovascular
As with other H_2-blockers, rare reports of arrhythmias such as tachycardia, bradycardia, asystole, atrioventricular block, and premature ventricular beats.

Gastrointestinal
Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and rare reports of pancreatitis.

Hepatic
In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg q.i.d. intravenously for 7 days, and in 4 of 24 subjects receiving 50 mg q.i.d. intravenously for 5 days. There have been occasional reports of hepatocellular, cholestatic, or mixed hepatitis, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in rare circumstances death has occurred. Rare cases of hepatic failure have also been reported.

Musculoskeletal
Rare reports of arthralgias and myalgias.

Hematologic
Blood count changes (leukopenia, granulocytopenia, and thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia and exceedingly rare cases of acquired immune hemolytic anemia have been reported.

Endocrine
Controlled studies in animals and humans have shown no stimulation of any pituitary hormone by ranitidine and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when ranitidine has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ranitidine, but the incidence did not differ from that in the general population.

Integumentary
Rash, including rare cases of erythema multiforme. Rare cases of alopecia and vasculitis.

Respiratory
A large epidemiological study suggested an increased risk of developing pneumonia in current users of histamine-2-receptor antagonists (H_2RAs) compared to patients who had stopped H_2RA treatment, with an observed adjusted relative risk of 1.63 (95% CI, 1.07 to 2.48). However, a causal relationship between use of H_2RAs and pneumonia has not been established.

Other
Rare cases of hypersensitivity reactions (e.g., bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE
There has been virtually no experience with overdosage with ranitidine injection and limited experience with oral doses of ranitidine. Reported acute ingestions of up to 18 g orally have been associated with transient adverse effects similar to those encountered in normal clinical experience (see **ADVERSE REACTIONS**). In addition, abnormalities of gait and hypotension have been reported. When overdosage occurs, clinical monitoring and supportive therapy should be employed.
Studies in dogs receiving dosages of ranitidine in excess of 225 mg/kg per day have shown muscular tremors, vomiting, and rapid respiration. Single oral doses of 1,000 mg/kg in mice and rats were not lethal. Intravenous LD_{50} values in mice and rats were 77 and 83 mg/kg, respectively.

DOSAGE AND ADMINISTRATION

Parenteral Administration
In some hospitalized patients with pathological hypersecretory conditions or intractable duodenal ulcers, or in patients who are unable to take oral medication, ranitidine injection may be administered parenterally according to the following recommendations:

Intramuscular Injection
50 mg (2 mL) every 6 to 8 hours. (No dilution necessary.)

Intermittent Intravenous Injection
1. ***Intermittent Bolus:*** 50 mg (2 mL) every 6 to 8 hours. Dilute ranitidine injection, 50 mg, in 0.9% sodium chloride injection or other compatible IV solution (see **Stability**) to a concentration no greater than 2.5 mg/mL (20 mL). Inject at a rate no greater than 4 mL/min (5 minutes).

2. ***Intermittent Infusion:***50 mg (2 mL) every 6 to 8 hours. Dilute ranitidine injection, 50 mg, in 5% dextrose injection or other compatible IV solution (see **Stability**) to a concentration no greater than 0.5 mg/mL (100 mL). Infuse at a rate no greater than 5 to 7 mL/min (15 to 20 minutes).

In some patients it may be necessary to increase dosage. When this is necessary, the increases should be made by more frequent administration of the dose, but generally should not exceed 400 mg/day.

Continuous Intravenous Infusion
Add ranitidine injection to 5% dextrose injection or other compatible IV solution (see **Stability**). Deliver at a rate of 6.25 mg/hr (e.g., 150 mg [6 mL] ranitidine injection in 250 mL of 5% dextrose injection at 10.7 mL/h).

For Zollinger-Ellison patients, dilute ranitidine injection in 5% dextrose injection or other compatible IV solution (see **Stability**) to a concentration no greater than 2.5 mg/mL. Start the infusion at a rate of 1 mg/kg per hour. If after 4 hours either a measured gastric acid output is >10 mEq/h or the patient becomes symptomatic, the dose should be adjusted upward in 0.5-mg/kg per hour increments, and the acid output should be remeasured. Dosages up to 2.5 mg/kg per hour and infusion rates as high as 220 mg/h have been used.

Pediatric Use

While limited data exist on the administration of IV ranitidine to children, the recommended dose in pediatric patients is for a total daily dose of 2 to 4 mg/kg, to be divided and administered every 6 to 8 hours, up to a maximum of 50 mg given every 6 to 8 hours. This recommendation is derived from adult clinical studies and pharmacokinetic data in pediatric patients. Limited data in neonatal patients (less than one month of age) receiving ECMO have shown that a dose of 2 mg/kg is usually sufficient to increase gastric pH to >4 for at least 15 hours. Therefore, doses of 2 mg/kg given every 12 to 24 hours or as a continuous infusion should be considered.

Dosage Adjustment for Patients with Impaired Renal Function

The administration of ranitidine as a continuous infusion has not been evaluated in patients with impaired renal function. On the basis of experience with a group of subjects with severely impaired renal function treated with ranitidine, the recommended dosage in patients with a creatinine clearance <50 mL/min is 50 mg every 18 to 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosing schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis. Elderly patients are more likely to have decreased renal function, therefore caution should be exercised in dose selection, and it may be useful to monitor renal function (see **CLINICAL PHARMACOLOGY: Pharmacokinetics: Geriatrics** and **PRECAUTIONS: Geriatric Use**).

Stability

Undiluted, ranitidine injection tends to exhibit a yellow color that may intensify over time without adversely affecting potency. Ranitidine injection is stable for 48 hours at room temperature when added to or diluted with most commonly used IV solutions, e.g., 0.9% sodium chloride injection, 5% dextrose injection, 10% dextrose injection, lactated ringer's injection, or 5% sodium bicarbonate injection.

Note: Parenteral drug products should be inspected visually for particulate matter and discoloration before administration whenever solution and container permit.

DIRECTIONS FOR PROPER USE OF PHARMACY BULK PACKAGE

This Pharmacy Bulk Package is intended for use in a Pharmacy Admixture Service. Under a laminar flow hood, dispense aliquots from vial into infusion fluids using a suitable sterile dispensing device. Use of a syringe with needle is not recommended.

The withdrawal of container contents should be accomplished without delay. However, should this not be possible, a maximum of 24 hours from initial closure entry is permitted to complete fluid transfer operations.

Discard unused solution from bulk package no later than 24 hours after initial entry.

HOW SUPPLIED

Ranitidine Injection USP, 25 mg/mL, containing phenol 0.5% as preservative, is available as 1000 mg, in a 40 mL pharmacy bulk package, individually boxed, **NDC 55390-618-01**.

Store at 20° to 25°C (68° to 77°F). See USP controlled room temperature. **Protect from light.** Store vial in carton until time of use.

Manufactured by	Manufactured for
Ben Venue Laboratories, Inc.	Bedford Laboratories™
Bedford, OH 44146	Bedford, OH 44146
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